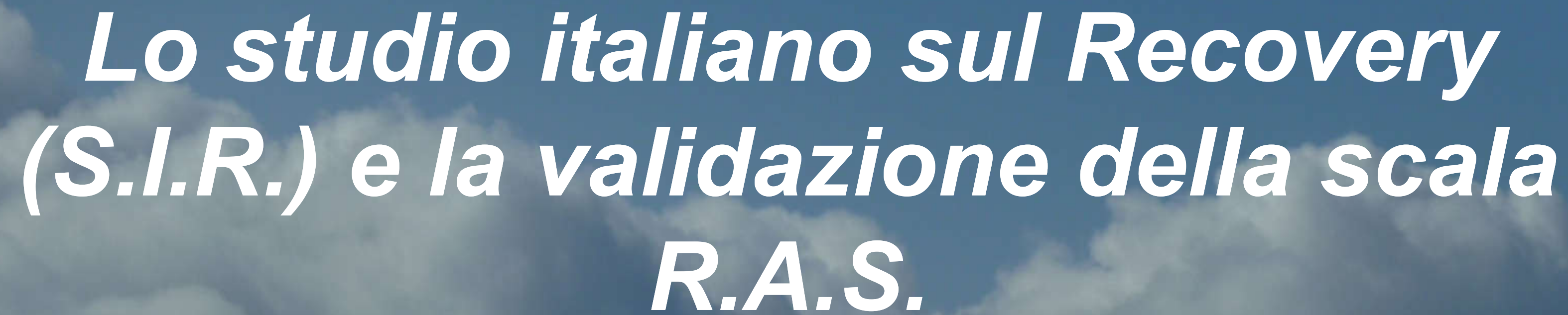


Lo studio italiano sul Recovery (S.I.R.) e la validazione della scala R.A.S.

Dario Lamonaca
C.S.M. Aulss 21 Legnago VR

IV ° Congresso Calabrese SIRP
Catanzaro, 13-14 novembre 2015

Recovery

Attitudine

Processo

Evento naturale

Esito

Open Forum

Recovery From Schizophrenia: A Concept in Search of Research

Robert Paul Liberman, M.D.
Alex Kopelowicz, M.D.

PSYCHIATRIC SERVICES ♦ http://ps.psychiatryonline.org ♦ June 2005 Vol. 56 No. 6

Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems

Mike Slade[1], Michaela Amering[2], Marianne Farkas[3], Bridget Hamilton[4], Mary O'Hagan[5], Graham Panther[6], Rachel Perkins[7], Geoff Shepherd[7], Samson Tse[8], Rob Whitley[9]

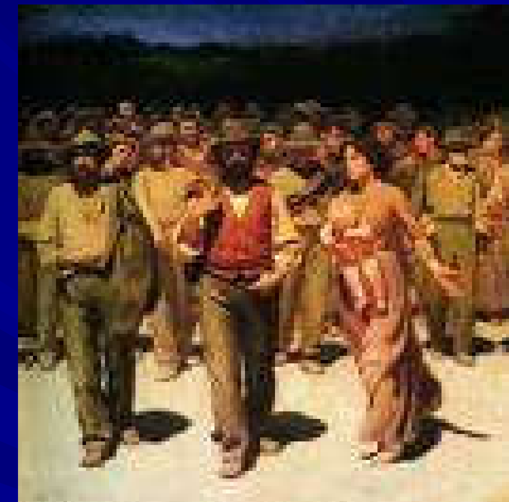
[1]King's College London, Health Service and Population Research Department, Institute of Psychiatry, Denmark Hill, London SE5 8AF, UK; [2]Department of Psychiatry and Psychotherapy, Medical University of Vienna, Austria; [3]Center for Psychiatric Rehabilitation, Boston University, West Boston, MA 02215, USA; [4]University of Melbourne, School of Health Sciences, Parkville, Melbourne 3010, Australia; [5]Education House, Wellington, New Zealand; [6]Redpanther Research, Auckland, New Zealand; [7]Centre for Mental Health, Maya House, London, UK; [8]Department of Social Work and Social Administration, University of Hong Kong, Hong Kong; [9]Douglas Hospital Research Centre, McGill University, Montreal, Canada

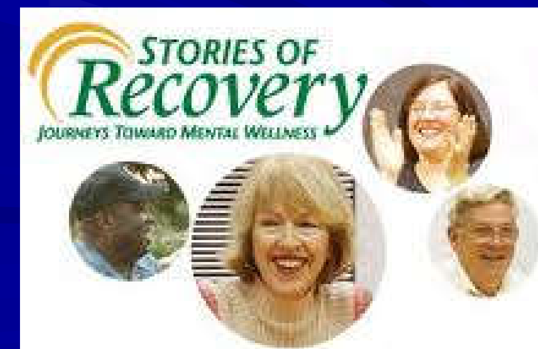
An understanding of recovery as a personal and subjective experience has emerged within mental health systems. This meaning of recovery now underpins mental health policy in many countries. Developing a focus on this type of recovery will involve transformation within mental health systems. Human systems do not easily transform. In this paper, we identify seven mis-uses ("abuses") of the concept of recovery: recovery is the latest model; recovery does not apply to "my" patients; services can make people recover through effective treatment; compulsory detention and treatment aid recovery; a recovery orientation means closing services; recovery is about making people independent and normal; and contributing to society happens only after the person is recovered. We then identify ten empirically-validated interventions which support recovery, by targeting key recovery processes of connectedness, hope, identity, meaning and empowerment (the CHIME framework). The ten interventions are peer support workers, advance directives, wellness recovery action planning, illness management and recovery, REFOCUS, strengths model, recovery colleges or recovery education programs, individual placement and support, supported housing, and mental health trialogues. Finally, three scientific challenges are identified: broadening cultural understandings of recovery, implementing organizational transformation, and promoting citizenship.

Key words: Recovery, mental health services, peer support workers, advance directives, wellness recovery action planning, individual placement and support, supported housing, mental health trialogues, organizational transformation, promoting citizenship

Il background storico del Recovery

- *Il ruolo dei processi di de-istituzionalizzazione*
- *Il superamento dell'idea di cronicità e il contributo delle ricerche longitudinali*
- *La testimonianza dei "consumers/survivors"*





Patricia Deegan, psicologo clinico

Direttore NorthEast Independent Living Program

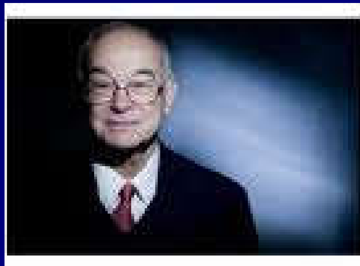
Robert Liberman, Direttore UCLA Center for Research on Treatment & Rehabilitation on Psychosis

Attivisti del Recovery Movement

Ex pazienti

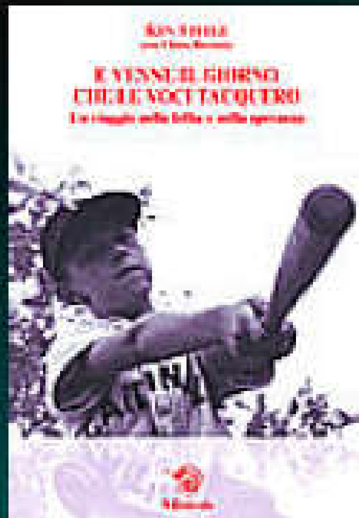
Dan Fischer, psichiatra

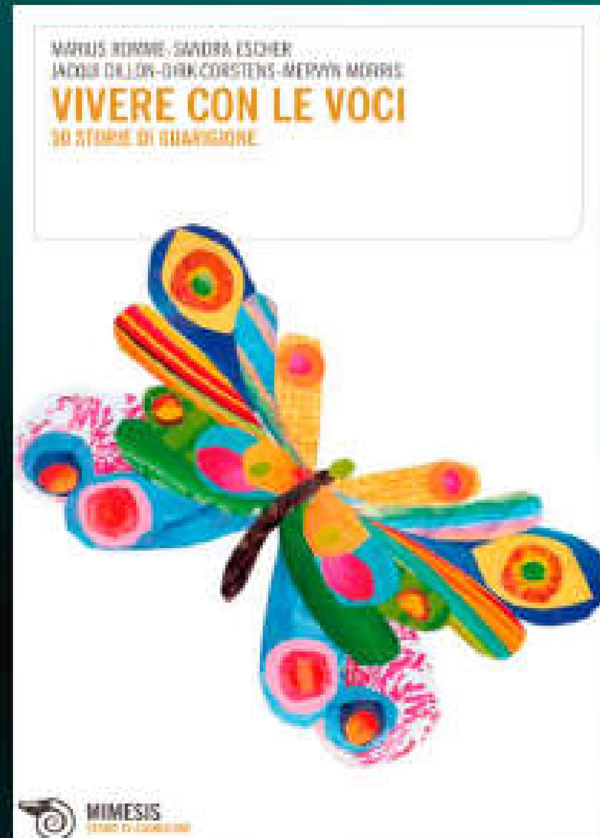
Direttore National Empowerment Center Massachusetts



Fred Frese, psicologo

Professore associato University NorthEastern Ohio College of Medecine




MARIUS ROMME-SANDRA ESCHER
JACQUI DILLON-DIRK CORSTENS-MERVYN MORRIS
VIVERE CON LE VOCI
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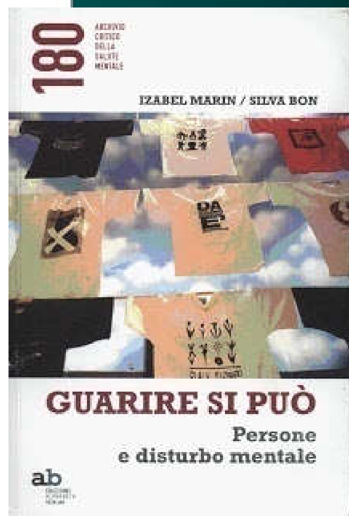

180
IZABEL MARIN / SILVA BON
GUARIRE SI PUÒ
Persone
e disturbo mentale
ab

Storie di recovery
LIVE

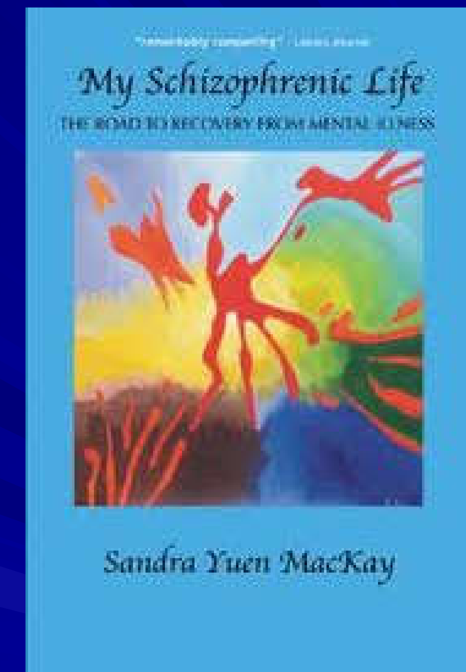
Long-term studies: people can recover from severe mental illness

Study	Sample Size	Follow-Up (in years)	% Significantly Recovered
Bleuler (1972)	208	23	53%-68%
Huber et al. (1979)	502	22	57%
Ciompi & Muller (1976)	289	37	53%
Tsuang et al. (1979)	186	35	46%
Harding et al. (1987)	269	32	62-68%

1. Bleuler (1978). The Schizophrenic Disorders. New Haven, Yale Press
2. Huber et al (1975). Long-term followup…Acta Psychiatrica Scand. 53:49-57.
3. Ciompi & Muller (1976). Lebensweg und alter…Berlin. Verlag Springer.
4. Harding et al. (1987). Vermont longitudinal study…Am. J. of Psychiatry 144: 718-735.
5. Tsuang,M. et al (1979). Long-term outcome…Arch. Gen. Psych. 36:1295-1301

Long-term studies: people can recover from severe mental illness

Study	Sample Size	Follow-Up (in years)	% Significantly Recovered
Hinterhuber (Austria)	157	30	75%
Kreditor (Russia)	115	20	84%
Marino (Bulgaria)	280	20	75%
Ogawa (Japan)	140	23	57%
Total of 9 studies	2028	20-37	66%



Recovery and people with severe mental disorders

Due "modelli" alternativi o complementari :

1. Il punto di vista dei "professionisti":

Recovery *dalla malattia*; recovery come *esito*

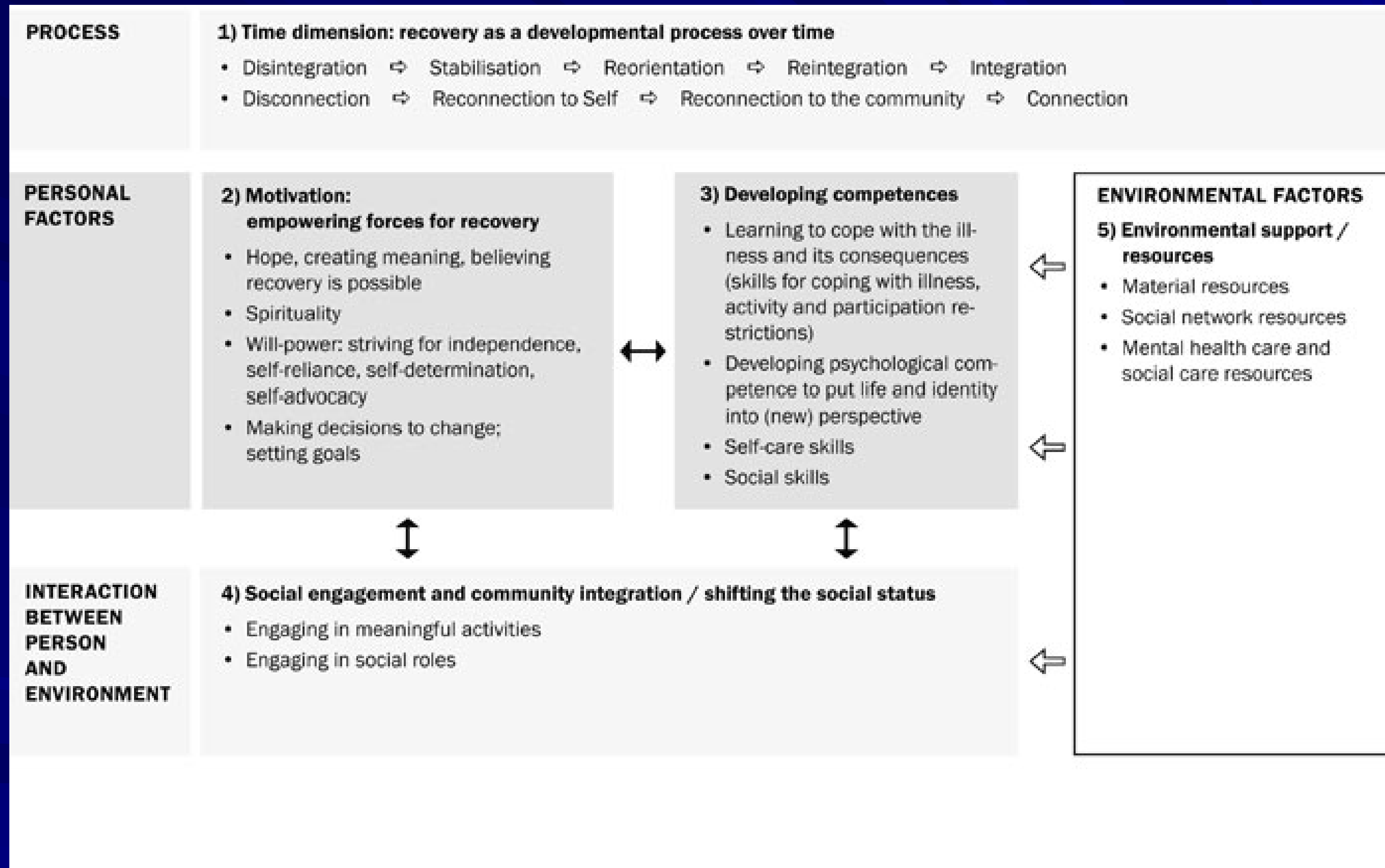
- Basato su evidenze cliniche ed epidemiologiche
- Correlato con gli interventi professionali
- Farmacoterapia
- Riabilitazione psicosociale

2. Il punto di vista degli "utenti":

Recovery *nella* malattia; recovery come *processo*

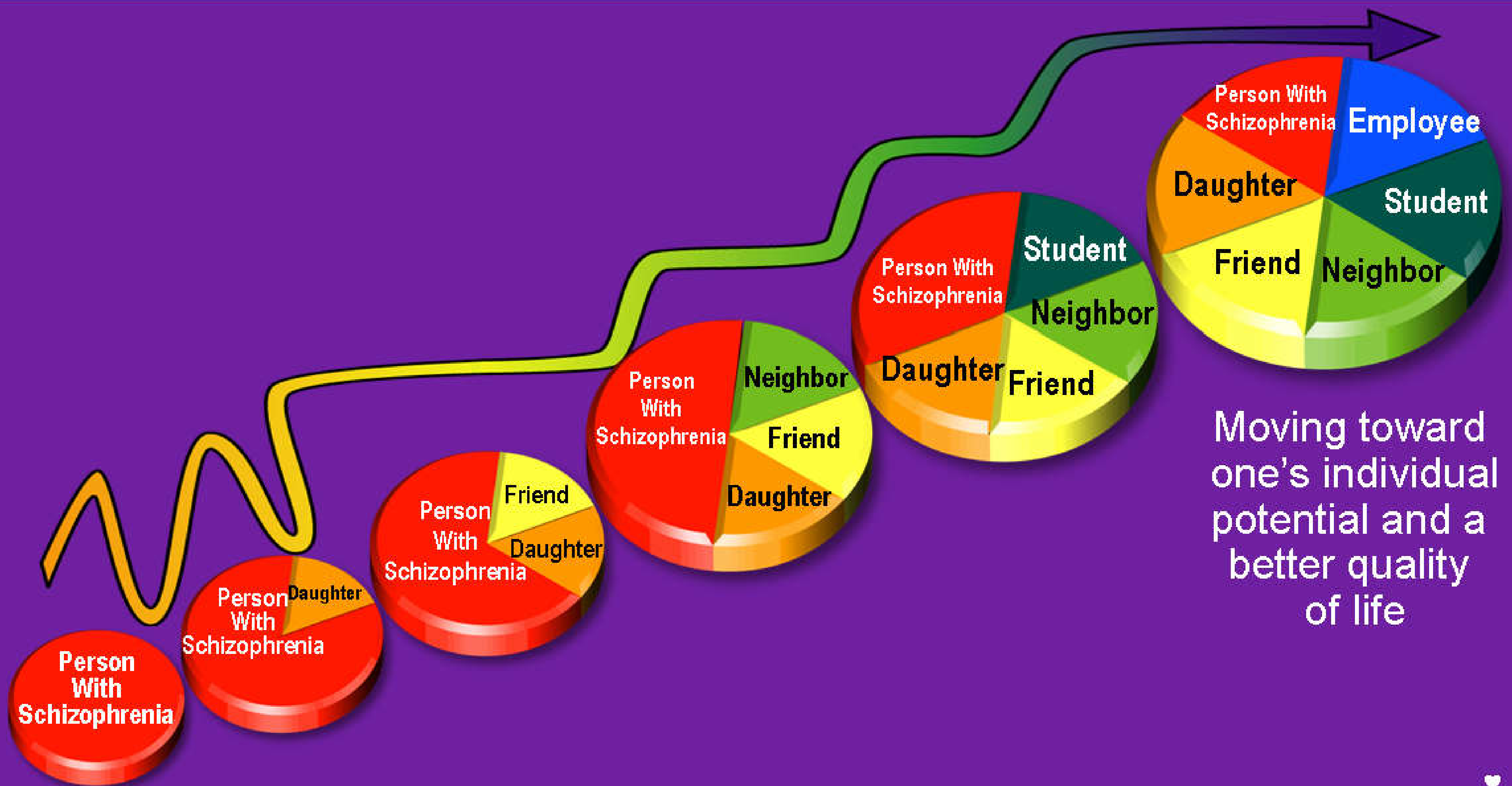
- Basato sui racconti in prima persona e studi qualitativi
- Correlato con alcuni interventi professionali ma anche self-help, cure informali, sforzi personali e "salute positiva"(resilienza, speranza, auto determinazione, etc.)

Understanding Recovery from Psychosis: A Growing Body of Knowledge



Wilken JP, Tidsskrift for Norsk Psykologforening, 2007

Optimizing Outcomes: The Process of Recovery[1]



1. Anthony WA. *Psychosocial Rehabilitation Journal.* 1993;16(4):11-23.
2. Adapted from: The Village. Available at: http://www.village-isa.org/Overview/psr_circle.htm.

Narrative Synthesis of Recovery Processes

Connectedness
- Peer support and support groups
- Relationships
- Support from others
- Community

Hope and optimism
- Belief in recovery
- Motivation to change
- Hope-inspiring relationships
- Positive thinking and valuing success
- Having dreams and aspirations

Identity
- Rebuilding positive sense of identity
- Overcoming stigma

Meaning
- Meaning in mental 'illness experience'
- Spirituality
- Meaningful life and social roles
- Meaningful life and social goals

Empowerment
- Personal responsibility
- Control over life
- Focusing upon strengths

Leamy , M et al (2011) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis BJPsych 199:445-452

Recovery and Severe Mental Illness: Description and Analysis

Robert E Drake, MD, PhD[1]; Rob Whitley, PhD[2]

[1] Professor of Psychiatry, Dartmouth Psychiatric Research Center, Lebanon, New Hampshire.
Correspondence: Dartmouth Psychiatric Research Center, Rivermill Commercial Center, Suite B4–1, Lebanon, NH 03766; robert.e.drake@dartmouth.edu.

[2] Assistant Professor of Psychiatry, Douglas Mental Health University Institute, McGill University, Montreal, Quebec.

- ***Hegarty**, 1994* — ***320 studi*** — ***40 %***
- ***Menezes**, 2006* — ***37 studi*** — ***42 %***
- ***Warner**, 2004* — ***114 studi*** — ***11-33 %***
- ***Jaaskelainen**, 2013* — ***50 studi*** — ***13,5 %***

CanJPsychiatry 2014;59(5):236–242

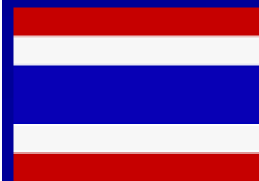
Details of studies included in the review.

Review

Consumer perspectives on the concept of recovery in schizophrenia: A systematic review

Diksy Jose[a,1], Ramachandra[b,2], K. Lalitha[b,3], Sailaxmi Gandhi[b,4,*], Geetha Desai[c,5], Nagarajaiah[b,6]

[a] Govt Mental Health Centre, Thrissur, Kerala, India
[b] Department of Nursing, NIMHANS (INI), Hosur Road, Bangalore 560029, Karnataka, India
[c] Department of Psychiatry, NIMHANS (INI), Hosur Road, Bangalore 560029, Karnataka, India



				connection with their environment
5	Tooth et al. (2003)	To understand the consumer perspectives on recovery	Qual-phenomenological 57 patients	Taking responsibility, having structure and organization, being like normal people, personal intention to living your life, process occurs in stages etc.
6	David et al. (2004)	To compare recovery concepts between professionals and general population	Quantitative survey	Significant difference between psychiatrist's and general population attitude towards recovery
7	Resnick et al. (2005)	To conceptualize and measure recovery orientation	Quantitative 1076 patients	Significant factors identified are: life satisfaction (.88), hope and optimism (.77)
8	Andresen et al. (2006)	To identify the stages of recovery based on consumer perception	Qual-grounded theory 94 patients	Five staged process. Stages are moratorium, awareness, preparation, rebuilding, growth
9	Jenkins and Song (2005)	To understand the subjective experience of recovery as reported by persons living with schizophrenia	Qual-ethnographic 90 patients	Process of awakening and improvement, gradual and non linear progression, incremental in nature with occasional set backs and subjective experience
10	Zanker (2008)	To explore the concept of recovery and reintegration relative to mental illness in low income countries	Qual-grounded theory 54 patients	Recovery is both process and outcome
11	Ng et al. (2008)	To understand the meaning of recovery as told by chronic schizophrenia patients	Qual-phenomenological 8 chronic schizophrenia patients	Multidimensional concept, full recovery is when the patient stops medication and has a steady job, disappearance of symptoms, independent living
12	Church et al. (2009)	To discover the meaning of mental health recovery to psychiatric survivors	Qual-grounded theory 10 patients	Recovery is a personal and collective journey and a site of struggle
13	Lysaker et al. (2010)	To compare the personal narratives of recovery with standardized scale	Qual-descriptive 103 patients	Wellness in relationship, enhanced connections, give and take relationship, self identification
14	Andresen et al. (2010)	To compare the consumer defined and clinical recovery measures	Quant-correlational 281 patients	Significant difference between clinical measurement and subjective experience of recovery
15	Noiseux and Ricard (2008)	To arrive at a theoretical explanation of recovery based on consumer perspectives	Qualitative 15 patients, 5 family members and 20 health professionals	Intrinsic, non linear progress, regain/rebuild sense of self on all biopsychosocial fields, manage imbalance between internal and external forces
16	Henderson (2011)	To understand West Australians' consumer perspectives about recovery	Qual-grounded theory 15 patients	Three phase process of adjusting or overcoming three fold losses: biomedical, psychological, and/or social
17	Coldwell et al. (2011)	To identify the contribution to	Qual-grounded theory	Complex process shaped by

The Psychiatrist (2010), 34, 465–470, doi: 10.1192/pb.bp.109.027409

Conceptualisation of recovery from psychosis: a service-user perspective

Lisa Wood,[1] Jason Price,[1] Anthony Morrison,[1,2] Gillian Haddock[2]

Box 1 Interpretative phenomenological analysis: key themes, subthemes and further themes of aspects important to a change in recovery.

Impacts on mental health

Reduction in symptoms of psychosis

- Preoccupation with experiences
- The content of experiences
- The frequency of experiences
- The duration of experiences
- The loudness of voices
- The origin of the experiences
- Perception of experiences
- Amount of distress
- Conviction

Emotional change

- Overcoming depression and low mood
- Feelings of happiness and enjoyment
- Overcoming anxiety and stress
- Overcoming anger and frustration
- Changes in the amount of emotions experienced

Self-change and adaptation

Personal change and belief

- Positive self-beliefs
- Redefining who you are
- Feeling less vulnerable
- Overcoming embarrassment
- Regaining personal freedoms and rights
- Having a positive outlook for the future

Behavioural change

- Improvements in sleep
- Energy and lethargy
- Motivation for change
- Reduction in self-harm and suicidal ideation
- Regaining independence
- Changes in drug and alcohol use

Social redefinition

Occupational change

- Stable living conditions
- Job seeking and maintaining employment
- Financial stability

Relationships and social behaviour

- Being less withdrawn and isolated
- Finding the ability to trust others
- Taking part in meaningful activities and hobbies
- Developing and depending on relationships with friends and loved ones
- Increasing social activity
- Overcoming being judged and stigmatised

Individualised coping mechanisms

Support and treatment

- Benefits of medication
- Benefits of therapies
- Peer support
- Support from loved ones and/or friends
- Receiving help from the mental health services
- Concerns over the side-effects of medication
- Importance of spirituality/religion

Understanding and control

- Help-seeking with experiences
- Recognising the early signs of becoming unwell
- Being able to cope with experiences
- Understanding your experiences and/or diagnosis
- Feeling empowered over your experiences
- Having control over experiences
- Thinking clearly about experiences
- Having control over own thoughts

Scopi della ricerca S.I.R 2

FASE 1 - QUANTItativa

- Applicazione di strumenti per la misurazione del recovery utilizzabili nella pratica clinica

(Recovery Assessment Scale – versione italiana)

FASE 2 - QUALItativa

- Raccogliere il punto di vista degli utenti sugli elementi cruciali per il loro processo di recovery
- Identificare i fattori favorenti o ostacolanti il recovery, per poter *ri-orientare* i servizi psichiatrici al recovery

Lombardia
3

Emilia-Romagna
1

Liguria
1

Piemonte
1

Lazio
1

Campania
1

Alto-Adige
2

Veneto
9

Dipartimento di Psicologia generale
Università di Padova

Puglia
4

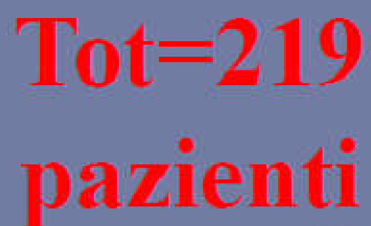
Molise
1

Marche
1

Tot=25 centri/11 regioni

Criteri di inclusione

- Diagnosi psichiatrica dello spettro psicotico
- Età compresa tra 18 e 65 anni
- Storia di malattia superiore a 5 anni
- Consenso informato allo studio



Criteri UCLA-Liberman

- Remissione sintomi
- Ruolo sociale appropriato
- Abilità di gestire compiti della vita quotidiana senza supervisione
- Interazioni sociali

Criteri considerati per la ricerca

- Nessun ricovero negli ultimi due anni
- Lavoro protetto/libero mercato/studente
- Autonomia nella norma
- Relazioni sociali regolari/pochi ma veri rapporti di amicizia

I miglioramenti in queste aree devono essere sostenuti per due anni o più.

Schizophrenia Bulletin 2004 30(4):1035-1041;

Examining the Factor Structure of the Recovery Assessment Scale

Patrick W. Corrigan, Psy.D., Executive Director, Mark Salzer, Ph.D., Assistant Professor, Ruth O. Ralph, Ph.D., Senior Research Associate (retired), Muskie School, Yvette Sangster, Founder and Lorraine Keck, M.D., Lorraine Keck is President

Center for Psychiatric Rehabilitation at Evanston Northwestern Healthcare Evanston, IL
University of Pennsylvania Philadelphia, PA
University of South Maine Lewiston, ME
Advocacy Unlimited Wethersfield, IL
GROW, Champaign, IL

Please address all correspondence to Dr. P. Corrigan, Center for Psychiatric Rehabilitation at Evanston Northwestern Healthcare, 1033 University Place, Ste. 450, Evanston, IL 60201; e-mail: p-corrigan2@northwestern.edu

This article follows up on earlier research examining the factor structure of a measure of recovery from serious mental illness. Exactly 1,824 persons with serious mental illness who were participating in the baseline interview for a multistate study on consumer-operated services completed ***the Recovery Assessment Scale (RAS) plus measures representing hope, meaning of life, quality of life, symptoms, and empowerment.*** Results of exploratory and subsequent confirmatory factor analyses of the RAS for random halves of the sample yielded five factors: personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and no domination by symptoms. Subsequent regression analyses showed that these five factors were uniquely related to the additional constructs assessed in the study. We compared these findings with those of other studies to summarize the factor structure that currently emerges on recovery

Fattori psicologici del Recovery
indagati dalla RAS

1. Fiducia in se stessi e speranza (11, 14, 15, 16, 20, 22, 24, 25, 36)
2. Disponibilità a chiedere aiuto (30, 31, 32)
3. Orientamento ad obiettivi e al successo (1, 2, 3, 4, 5)
4. Fiducia negli altri (6, 37, 39, 40)
5. Non sentirsi dominati dai sintomi (27, 28, 29)

Punteggio

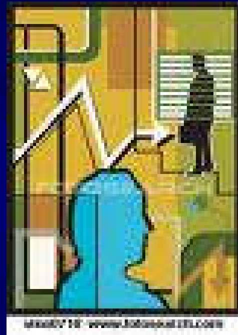
41 - 205

La ricerca S.I.R.2 (2012-13)

HoNoS

Health of the Nation Outcome Scale

(Lora, 2001)



Empowerment

SESM (Straticò,2007)

R.A.S.

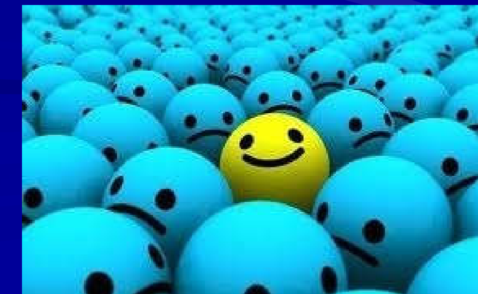
Recovery Assessment Scale

Autostima

Questionario R.S.E. (Prezza,1997)

Qualità della vita

MANSA (Priebe, 1999)



Intervista sui fattori di Recovery

Caratteristiche del campione
N=219

Età media	**44 anni**
Sex	**Maschile (68,7%)**
Scolarità	**11 anni di istruzione (59,9%)**
Stato Civile	Nubile/Celibe (79,9%)
Diagnosi	**Psicosi Schizofrenica (70,17%)**
Situazione abitativa	Vive con la famiglia di origine (41,4%)
Situazione lavorativa	Non occupato (43,4%)
Relazioni sociali	Pochi ma veri rapporti di amicizia (32,4%)
Autonomia quotidiana	Nella norma (68,5%)
Età media di esordio malattia	**25,68**
Durata media di malattia	**18,08**
Ricoveri negli ultimi 2 anni	**No (82,2,3%)**

Studio Italiano sul Recovery

SIR 2

Individuazione utenti

Raccolta dati anagr., clinici, cons. inf.

>= 40% (2-5)

Criteri UCLA

60% (3 – 10)

Non criteri UCLA

FASE 1

RAS, SESM, MANSA, HoNOS, RSE

Utenti in Recovery (n.65)

Utenti non in Recovery (n.151)

Familiari di utenti in Recovery (n.45)

FASE 2: Intervista

Sottoscale scala RAS-Coerenza interna
α >0,60 accettabile >0,80 eccellente

Domini	Sottoscale	α di Chronbach
Fattore 1	Fiducia e speranza personali (11,14,15,16,20,22,24,25,36)	**0,80**
Fattore 2	Prontezza nel chiedere aiuto (30,31,32)	**0,70**
Fattore 3	Orientamento al successo e all'intraprendenza (1,2,3,4,5)	**0,81**
Fattore 4	Fiducia negli altri (6,37,39,40)	**0,60**
Fattore 5	Non essere dominati dai sintomi (27,28,29)	**0,66**
Ras tot		**0,93**

Validità convergente

	RSE	*SESM*	*Mansa*	*HoNos*
Personal confidence and hope	**.64****	.66**	.59**	-.13
Willingness to ask for help	.39**	**.41****	.17*	-.13
Goal and success orientation	.52**	.58**	.45**	-.20**
Reliance on others	.23**	.29**	**.20****	.03
No domination by symptoms	.46**	.43**	.44**	**-.17***
RAS Total Score	**.65****	**.67****	.-17*	**.57****

Validity convergent/divergent. * p<.05; **=p<.001.
Note: RSE=Rosenberg Self Esteem; SESM= Empowerment Scale; MANSA=Manchester AssessmentQuality of Life; HoNos=Health of the NationOutcome Scale–Roma.

Validità discriminante

Accordo positivo: 78,5 % (51 di 65)

Accordo negativo: 61,2 % (90 di 147)

Punteggio cut off: => 158

Risultati Fase 1

- I risultati sono in sintonia con il lavoro di validazione effettuato negli Stati Uniti **(Corrigan et al., 2004);**
- La scala Ras mostra un' ottima coerenza interna **(alfa di Cronbach 0 .93);**
- La scala Ras sembra abbia una capacità discriminante tra le persone in fase di recovery e quelle che non lo sono (***Punteggio cut-off = > 158***);

- Vi è stata una percentuale significativa positiva (78, 5%)di accordo tra la scelta effettuata dagli operatori in base ai criteri di Liberman e il punteggio della RAS

- La discrepanza dei 51 pazienti valutati come “non in recovery” dai clinici ma che hanno riportato un punteggio superiore a 160, 27 soddisfacevano 3 su 4 criteri di Liberman, 14 su 51 2 su 4;

- La RAS presenta correlazioni positive con la Rosemberg, SESM e la MANSA, e negative con la HoNos (Validità convergente /costrutti affini ma non uguali)

Advancing Recovery Science: Reliability and Validity Properties of the Recovery Assessment Scale

Mark S. Salzer, M.A., Ph.D.
Eugene Brusilovskiy, B.A., M.U.S.A.

Objective: The promotion of recovery is the driving philosophy underlying national, state, and local mental health systems. Although numerous recovery-oriented measures have been developed in response, the scientific assessment of recovery measures has lagged behind. The purpose of this literature review was to review the psychometric properties of the Recovery Assessment Scale (RAS), which is arguably the most commonly used measure of recovery in the published literature. Such information is critical for advancing recovery science. ***Methods:*** A thorough literature search using the search term "Recovery Assessment Scale" was conducted in August 2012, yielding a total of 222 articles published from around the world. A total of 77 articles that included psychometric data on the RAS were used in this review. ***Results:*** Means and standard deviations across studies were fairly consistent. Overall, the studies indicate very good results for internal consistency, test-retest reliability, and interrater reliability. A number of studies also reported consistent factor structures for the measure. The RAS was found to have positive associations with other related constructs and negative associations with constructs such as symptoms. Finally, the RAS appears to be sensitive to change over time. ***Conclusions:*** The review found significant evidence to support the use of the RAS in recovery science as a means to measure recovery and to include it in mental health research. (*Psychiatric Services* 65:442–453, 2014; doi: 10.1176/appi.ps.201300089)

the extent to which respondents (consumers, providers, and others) are favorable toward the idea that achieving recovery is possible. These measures also assess knowledge and beliefs about recovery and recovery-oriented practices. Third are measures of respondents' perceptions of recovery-promoting environments, which include their opinions about the extent to which recovery-oriented policies, programs, and practices are in place.

Recovery-oriented research is still at a relatively early stage, especially compared with research examining other constructs, such as symptoms or cognitive functioning. And just like what happened in the early days of clinical outcome studies, thorough development and examination of evidence will be important to ensure that these measures meet rigorous measurement standards. This scrutiny

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- ***E' importante esaminare l'impatto degli interventi sull'esperienza personale di recovery***
- ***E' possibile utilizzare la RAS per valutare il proprio attuale stato di recovery e l'evoluzione nel tempo***
- ***Le sottoscale RAS possono essere utilizzate per interventi mirati***

Rampafoeu…

Riciapete…

An suma n'repiju…

Rretuollt…

Arrpgjt…

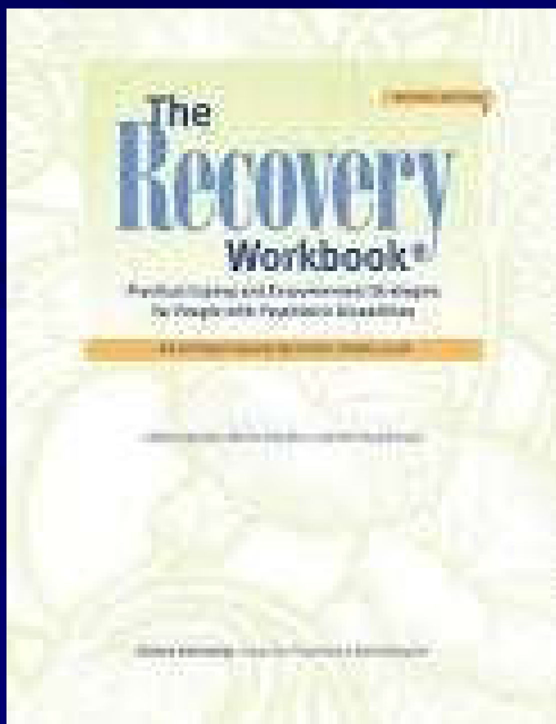
Aò aripijete…

Arripijate ambress…

Arricupigghiti…

"L'esperienza di recovery da una malattia mentale implica non solo recuperare un ruolo valido, ma anche riprendersi dagli effetti della diagnosi e dei trattamenti (es. discriminazione, perdita dell'autodeterminazione, mancanza di opportunità, progetti di vita compromessi), al pari degli effetti del riprendersi dalla malattia in sé" ***Anthony, 2002; Davidson, 2005***

I riferimenti…



1) Come è cominciato tutto ciò ?
2) In che modo si è accorto di avere un problema ?
3) Come ha cercato di fare fronte a questa situazione ?
4) A chi ha chiesto aiuto ?
5) Come ha visto la sua richiesta di aiuto al servizio ?
6) Quale tipo di aiuto ricevuto è stato per lei più utile ?
7) Chi o cosa ha influito maggiormente nel suo percorso di guarigione ?
8) Quali sono stati i fattori che hanno ostacolato maggiormente il suo percorso ?
9) Ci sono stati dei momenti "speciali" che hanno contribuito al suo miglioramento ?
10) Cosa significa per lei guarigione ?
11) Come è cambiata, se è cambiata, l'idea si sé stesso ?
12) Come è cambiata, se è cambiata, l'idea degli altri su di lei ?
13) Come descriverebbe il suo percorso dall'inizio ad oggi ?
14) Come immagina il suo futuro ?

R. Mezzina, I. Marin,

Riv. Sperim, Fre, 2006

Fattori favorenti il recovery

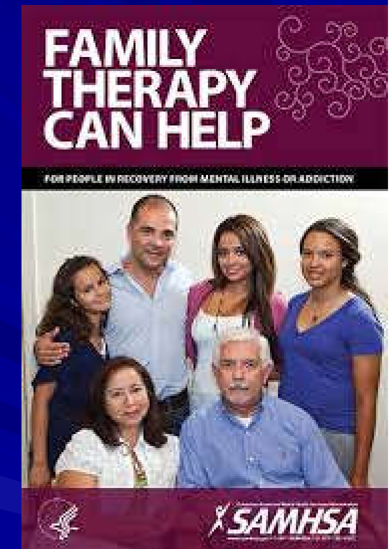
- ABILITA' DI GESTIONE DELLA MALATTIA
- PERSONE DI SUPPORTO
- FARE ATTIVITA' SIGNIFICATIVE
- DETERMINAZIONE
- SENSO DI CONTROLLO
- VISIONE POSITIVA DEL PRESENTE E FUTURO

Fattori ostacolanti il recovery

- *STIGMA INTERNO ED ESTERNO*
- *SINTOMI PERSISTENTI*
- *MANCANZA DI RISORSE*
- *OSTACOLI LEGATI AL SERVIZIO*
- *GESTIONE EVENTI STRESSANTI*

Cosa dicono i familiari

- *SOLLIEVO E INCERTEZZA*
- *FARE I CONTI CON CIO' CHE SI E' PERSO*
- *OSTACOLI: FREDDEZZA, DISTACCO, DISINTERESSE*
- *RISPETTO E STIMA NONOSTANTE TUTTO*
- *ESSERE RESI "ESPERTI", PARTECIPI E CONSAPEVOLI*



Subjective, “individual” aspects of recovery

- ***Process of personal growth and development (new learning experiences)***

- ***To be able to cope with personal and social disabilities of the disease (anti-stigma)***

- ***Re-gaining motivation, self-esteem, hope, autonomy, empowerment, quality of life***

- ***Finding back to a satisfying and self guided life***

Schrank & Amering, 2007;
Brekke & Nakagami , 2010

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REVIEW ARTICLE

Identifying the facilitators and processes which influence recovery in individuals with schizophrenia: a systematic review and thematic synthesis

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Abstract

Background: Research is required to better understand the psychosocial factors that influence the recovery of individuals with schizophrenia.

Objective: To conduct a systematic review and thematic synthesis and identify the factors which influence recovery.

Methods: Major electronic databases were searched from inception until February 2014. Qualitative articles were included that considered the concept of recovery from individuals with schizophrenia, their caregivers or health care professionals. Methodological quality was assessed and studies were thematically synthesised.

Results: Twenty articles involving 585 individuals with schizophrenia, 298 primary care givers or close sources of support and 47 health care professionals were included. The results identified and detailed the psychosocial factors and processes that influenced recovery. The factors which promoted recovery included: (1) adjustment, coping and reappraisal (2) responding to the illness (3) social support, close relationships and belonging. The factors which challenged recovery included: (1) negative interactions and isolation (2) internal barriers (3) uncertainty and hopelessness.

Conclusion: Health care professionals and researchers will benefit from a greater understanding of the psychosocial factors which influence recovery for individuals with schizophrenia. Implications are discussed within the text.

Keywords

Qualitative, recovery, schizophrenia, synthesis, well-being

History

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Conference paper

RECOVERY – RESHAPING OUR CLINICAL AND SCIENTIFIC RESPONSIBILITIES

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SUMMARY

Context: *Advocacy for Recovery has been joined by research offering new perspectives on mental health policy, treatment, rehabilitation and anti-discrimination efforts.*

Objectives: *Chances and challenges of a Recovery model for the mental health field will be presented and discussed.*

Key messages: *Recovery is currently widely endorsed as a guiding principle of mental health policy. New rules for services, e.g. user involvement and person-centred care, as well as new tools for clinical collaborations, e.g. shared decision making and psychiatric advance directives, are being complemented by new proposals regarding more ethically consistent anti-discrimination and involuntary treatment legislation as well as participatory approaches to evidence-based medicine and policy.*

Recovery advocacy has been joined by research on recovery and resilience resulting in new data on the long-term perspectives of people experiencing common as well as severe mental health problems. Definitions of remission and recovery as well as the concept of chronicity are under debate. Research questions regarding recovery as a process as well as an outcome warrant scientific efforts enabling the integration of different perspectives as well as different methodologies.

Conclusions: *Consequences and challenges of the Recovery model need to be tackled from different perspectives by clinicians, researchers, policy makers and – essentially - users and carers and their representatives in order to be fully explored and brought to life.*

Key words: *recovery – evidence base – user involvement - trialogue*

PERSPECTIVE

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Recovery, not progressive deterioration, should be the expectation in schizophrenia

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	Provider-Determined		Consumer-Determined
	Coercive	Paternalistic	Recovery-Oriented
Program regulatory mechanisms	Contingencies (punishment focus) Enforced dependency	Contingencies (reward focus) Incentives for dependency	Non-contingent Incentives for autonomy and personal accountability
Associated practices	Mandated psychotropic medication Deficit-focus, Boilerplate treatment plans, Coercive treatments (threats of hosp., outpatient commitment, restraints) No consumer input on org. Minimal choice	Emphasis on medications Maintenance-focus Some individualization in treatment Clinician-driven treatment (with input from consumer) Pro forma mechanisms for consumer input Moderate choice (e.g., medication type)	Medications part of overall treatment plan Recovery-focus Individualized (e.g., consumer's own words) Consumer-driven (with input from clinician) Consumer input basic to org. Consumer as source of control
Impact on consumer's self-regulation	Non-intentional, Feelings of incompetence, Lack of control, Helplessness	Compliant, External motivation (based on other's expectations), Dependent	Self-agency Internal motivation Independent

Less Recovery Oriented ◄────────► More Recovery-Oriented

RECOVERY SUPPORT TASKS

The job of mental health professionals

1. Fostering relationships
2. Promoting well-being
3. Offering treatments
4. Improving social inclusion

Slade M (2009) *The contribution of mental health services to recovery*,
Journal of Mental Health, **18**, 367-371.

Psychosocial treatments to promote functional recovery

Social skills training	• Coinvolge un numero di dimensioni importanti per il recovery • Presenta ampi effetti sul funzionamento nella comunità
Cognitive Behavioural Therapy	• Efficace nella riduzione dei sintomi positivi e negativi • Include alcuni aspetti del funzionamento nella comunità e della QoL
Cognitive Remediation	• Integra trattamenti specifici per migliorare target diversi (es. cognizione e abilità lavorative) • Coerente con il modello del recovery
Social Cognition Training	• Gli individui possono migliorare le prestazioni in una serie di processi cognitivi e sociali collegati al successo nel funzionamento sociale (es. percezione emotivo-affettiva)

QoL, quality of life

Kern et al. Schizophr Bull 2009;35:347–361

Background on Recovery and Recovery Orientation

- How can MH programs enhance feelings of competency?
  - Skills-based interventions (ADLs, work skills, social skills)
  - Employment
  - Self-management of mental illness (coping with symptoms)

Mancini et al, 2010

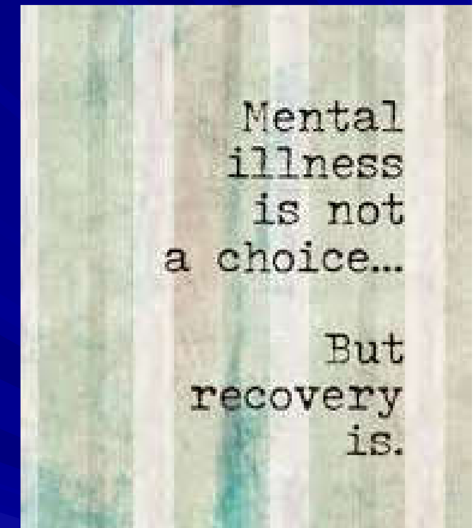
Background on Recovery and Recovery Orientation

- How can MH programs enhance feelings of relatedness?
  - Family-based interventions (psychoed. groups, contact w/ family members)
  - Focus on community integration (non-mental health activities)
  - Fostering relationships among consumers (group outings; special events)

Mancini et al, 2010

Quali interventi promuovono il recovery ?

- ***Illness management and recovery***
- ***Supported housing***
- ***IPS***
- ***Rivedere le pratiche inefficaci alla luce dell'esperienza degli utenti***



Drake and Whitley, 2014

Pratica orientata al Recovery

(Davidson et al., 2009)

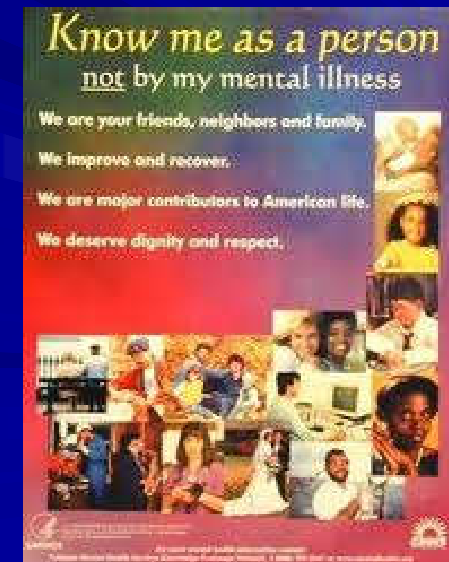
- Primarieta' della partecipazione
- Favorire l'accesso e il coinvolgimento
- Garantire la continuita' della cura
- Utilizzare una valutazione basata sui punti di forza
- Offrire una pianificazione individualizzata del percorso di Recovery
- Fungere da "guida per il Recovery"
- Conoscere e sviluppare l'inclusione comunitaria
- Identificare e affrontare le barriere al Recovery

Conclusioni…

- *La malattia mentale non è un destino*

- *La salute mentale non è per forza l'assenza di sintomi*

- *E' comunque possibile impegnarsi per una migliore qualità di vita*



- *Ai servizi di SM spetta di facilitare il recovery*

What outcomes are realistic

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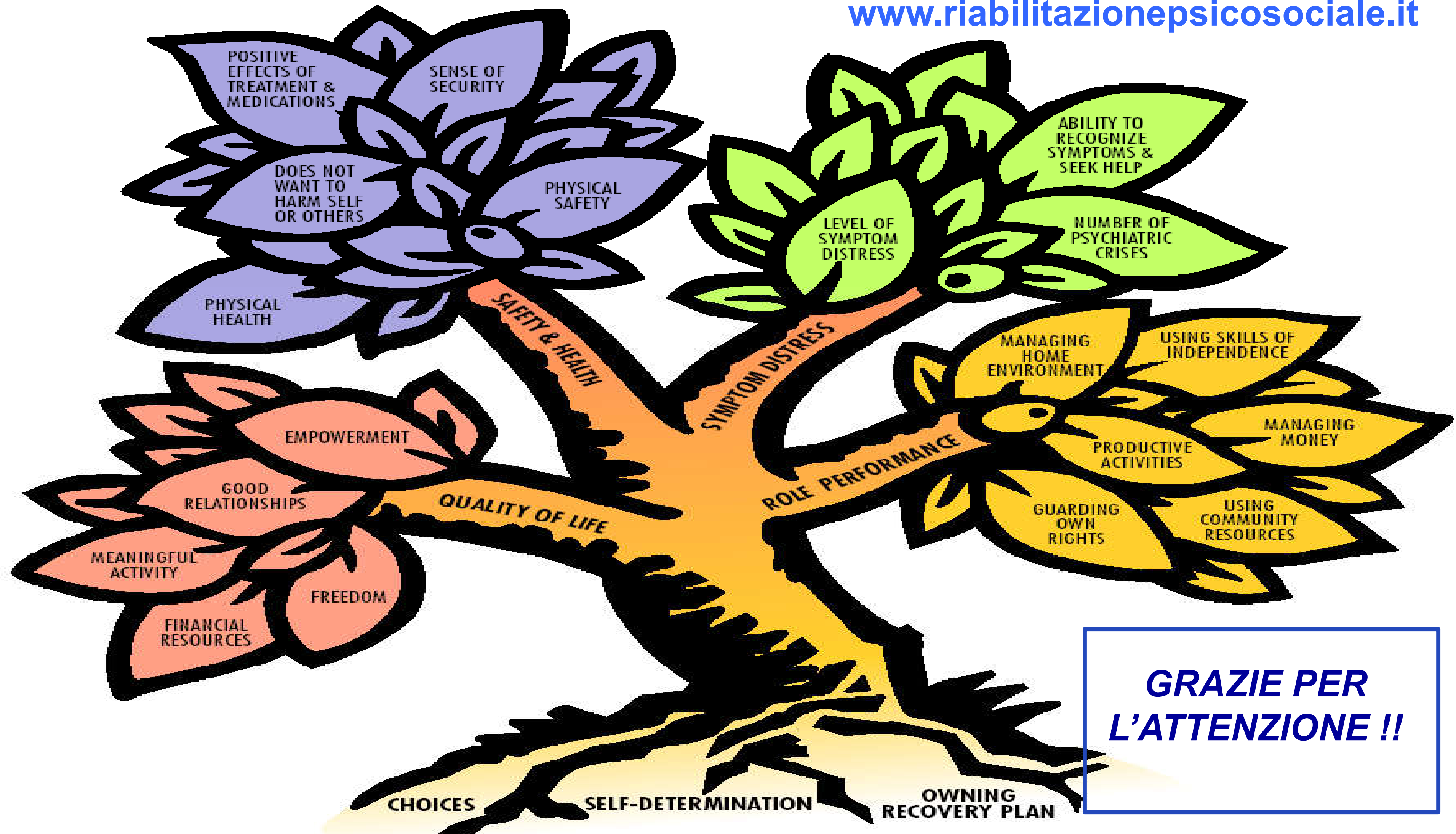

GRAZIE PER L'ATTENZIONE !!